STATE UNIFORM STAMP APPLICATION

To: Immunization Branch
California Dept. of Health Services
850 Marina Bay Parkway, Building P
Richmond, CA 94804-6403

Please Type All Information

Name (last) (first) (middle)		California medical license (certificate) number		Year issued
Office address (number, street)	City	County	ZIP code	Telephone number / FAX number
Home address (number, street)	City	County	ZIP code	Telephone number

Medical Specialty

☐ Family Medicine ☐ Pediatrics ☐ Internal Medicine ☐ Industrial Medicine ☐ Other _____

Employer name (if not self-employed)

Address (number, street)	City	State	ZIP code

Title of applicant

I agree to comply with all guidelines established by the State of California, Department of Health Services pertaining to the use of the State Uniform Stamp. I understand that the stamp remains the property of the State of California, Department of Health Services and is subject to recall at the discretion of the Department.

Signature of applicant	Date

For Official Use Only

Application: ☐ Approved ☐ Denied	Stamp number	Date application received
Impression of stamp		Date stamp mailed
		Date notification received
		Date stamp lost
		Date duplicate mailed
		Date duplicate received

Signature